**Universal Medical Record Release Authorization (UMRRA)**
**Patient Consent to Participate in the eHealthConnecticut Health Information Exchange (HIE)**

I understand that if I give consent below, I am allowing eHealthConnecticut to release and provide access to ALL of my medical records to my health care providers, health insurers, and other participating eHealthConnecticut organizations. Furthermore, I hereby intend to instruct all of my providers, including hospitals, physicians, clinics and other licensed providers who participate in the eHealthConnecticut HIE, to send and receive my personal health information, as described in this document, to eHealthConnecticut. If I sign this form as the Patient's Legal Representative, I understand that all references in this form to "me" or "my" refer to the Patient.

1. **Purpose:** I understand that my Medical Records disclosed to the eHealthConnecticut HIE will be used to provide me with medical treatment, to assess/improve the quality of medical care delivered by my health care providers, to facilitate public health reporting, or facilitate health care operations of my insurance company.

2. **Types of Information Included in this Authorization:** I understand that this Authorization permits access to ALL of my available Medical Records, including but not limited to, information related to drug/alcohol abuse, HIV/Aids status, treatment, or testing; genetic disease or genetic tests; family planning/reproductive care; sexually transmitted diseases; mental health, emergency room records, nursing notes, laboratory results, pathology reports, x-ray reports, films, and all other personal health information transmitted to eHealthConnecticut as allowable under applicable law. If any of the information to be released constitutes a psychiatric communication or a communication with a psychologist, or any other mental health worker, this authorization will serve as my written release of that information.

3. **Electronic Health Information Sources:** Information accessed through eHealthConnecticut comes from a variety of sources ("Electronic Health Information Sources"). These Electronic Health Information Sources may include participating providers, other health care providers (such as pharmacies and clinical laboratories), health insurers, the Connecticut State Medicaid program, other health information exchanges, and other entities participating in the eHealthConnecticut Health Information Exchange. A list of current Electronic Health Information Sources may be found at www.ehealthconnecticut.org. This list may change.

4. This Authorization permits access to personal health information created both before and after the date I sign this form. I understand that information about me may be re-disclosed only to the extent permitted by applicable laws and regulations. I understand that if the person or the entity that receives the information is not a health care provider or health plan covered by the federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

5. I understand that if I give consent, my consent will remain in effect until the day I withdraw consent or the eHealthConnecticut HIE stops operating, whichever comes first. Such withdrawal of consent must be provided in writing by submitting an 'eHealthConnecticut Denial of Participation in the HIE' form or the equivalent form maintained by the provider to one of the participating eHealthConnecticut entities. The entity to which I submit the form will provide me with a copy of the signed form. If I withdraw consent, access will no longer be available to Medical Records about me through the eHealthConnecticut HIE unless and until I again give consent by signing and completing a new Authorization form. The withdrawal of consent will not affect the exchange of my Medical Records made while my consent was in effect.

6. I understand that if I complete the separate 'eHealthConnecticut Denial of Participation in the HIE', there will be no access to my Medical Records through eHealthConnecticut, even in an emergency situation.

7. I recognize that state and federal privacy laws allow the State of Connecticut, particularly the Department of Public Health, to have access to my personal and health information for the purpose of public health activities including quality measures, and when such disclosure is required by law.

8. I understand that my health insurer(s) will have access to my Medical Records for Disease Management, Case Management and Quality Improvement purposes. Health Insurers will not use this information for claim or coverage determination.

9. I understand that the decision to participate in the eHealthConnecticut HIE is voluntary. No health care provider participating in the HIE will deny me medical care and my insurance eligibility will not be affected if I do not sign this authorization to participate.

10. I understand that I can access a list of participating eHealthConnecticut HIE health care providers and other entities by going to www.ehealthconnecticut.org.

11. I understand that I have the right to request a copy of any of my Medical Records used or disclosed by the eHealthConnnecticut HIE as a result of this consent to participate.

12. I understand that identified data may be used by the eHealthConnecticut HIE for research, evaluation, and quality improvement purposes.

13. I understand that eHealthConnecticut will comply with all federal law to protect patient privacy and will prohibit the sale of patient information for commercial marketing purposes.

14. I understand that I will receive a copy of this form after I sign it.

I have reviewed the above information and hereby authorize and consent to allow eHealthConnecticut to release and provide access to ALL of my medical records to my health care providers, health insurers, and other participating eHealthConnecticut organizations. I understand that I may withdraw my consent at anytime. I have received a copy of the Notices of Privacy Practices.

I understand that this **authorization expires** when revoked in writing by submitting an 'eHealthConnecticut Denial of Participation in the HIE' or the equivalent form maintained by the provider to one of the participating eHealthConnecticut entities, or if the eHealthConnecticut HIE stops operating, whichever comes first.

______________________________ ______________________________
Patient Name Patient Date of Birth

____________________________________________________________
Patient Address/ City/ State/ Zip Code

______________________________ ______________________________
Signature of Patient or Patient's Legal Representative Date of Signature

______________________________ ______________________________
Print Name of Patient's Legal Representative Relationship to patient (parent, guardian, other________)

**If patient is a minor:**

______________________________ ______________________________
Signature of Parent Date of Signature

Name of eHealthConnecticut participating entity where this Authorization was signed: ______________________